Washington State Department of Health

Immediately notify
DOH Communicable Disease Epidemiology
Phone: 877-539-5344

Botulism, infant

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed** ☐ **Probable**
By: ☐ **Lab** ☐ **Clinical** ☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Poor feeding**
☐	☐	☐	☐	**Constipation**
☐	☐	☐	☐	Weakness
☐	☐	☐	☐	Head drooping
☐	☐	☐	☐	Eyelids drooping (ptosis)
☐	☐	☐	☐	Cry weak or altered
☐	☐	☐	☐	Breathing difficulty or shortness of breath
☐	☐	☐	☐	Diarrhea Maximum # of stools in 24 hours: ____

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	**Floppy or weak baby**
☐	☐	☐	☐	**Failure to thrive**
☐	☐	☐	☐	**Respiratory distress**
☐	☐	☐	☐	Paralysis or weakness
				☐ Acute flaccid paralysis ☐ Asymmetric
				☐ Symmetric ☐ Ascending ☐ Descending
☐	☐	☐	☐	Mechanical ventilation or intubation required during hospitalization
☐	☐	☐	☐	Admitted to intensive care unit

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy

Laboratory

Collection date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	**Botulinum toxin detection (serum, gastric aspirate or stool)**
				☐ Serum ☐ Stool
				☐ Gastric aspirate ☐ Food
☐	☐	☐	☐	***C. botulinum* isolation (stool or gastric aspirates)**

NOTES

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter onset date/time (first sx) in heavy box. Count backward to determine probable exposure period

	Exposure period		onset
Hours from onset:	- 168	-12	
Calendar date/time:			

EXPOSURE (Refer to dates above)

Y	N	DK	NA	
☐	☐	☐	☐	Travel out of the state, out of the country, or outside of usual routine Out of: ☐ County ☐ State ☐ Country Dates/Locations: _____ _____ _____

Y	N	DK	NA	
☐	☐	☐	☐	If infant, breast fed
☐	☐	☐	☐	Infant formula
☐	☐	☐	☐	Commercial baby food
☐	☐	☐	☐	Honey (e.g. honey-filled pacifier, honey water)
☐	☐	☐	☐	Corn syrup
☐	☐	☐	☐	Home canned food
☐	☐	☐	☐	Dried, preserved, or traditionally prepared meat (e.g. sausage, salami, jerky)
☐	☐	☐	☐	Preserved, smoked, or traditionally prepared fish
☐	☐	☐	☐	Known contaminated food product

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PATIENT PROPHYLAXIS AND TREATMENT

Botulism antiserum given ☐**Y** ☐**N** ☐**DK** ☐**NA** Date/time given: ___/___/___ _____ AM / PM

PUBLIC HEALTH ISSUES

Y	N	DK	NA	
☐	☐	☐	☐	Outbreak related

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____